PATIENT INFORMATION

Name _____

Address _____

City, State, Zip Code _____

Home Phone _____ Marital Status _____

Date of Birth _____ Social Security Number _____

Dentist (who referred you today?) _____

Employer _____ Work Ph. _____

Person responsible for payment _____

Relationship to patient _____ Home Ph. _____

Spouse (or parent's) name _____

Spouse (or parent's) employer _____

Address _____ Work Ph. _____

Have you ever had root canal treatment? _____

Montgomery
ENDODONTICS, PC
James J. Kamburis, DMD

American Association of Endodontists
Specialty Member

MEDICAL HISTORY

1. Check any of the following which applies to you:

- ❑ High blood pressure
- ❑ Heart Problems:
  - ❑ Mitral valve prolapse (MVP)
  - ❑ Heart murmur
  - ❑ Heart valve replacement
  - ❑ Heart surgery
  - ❑ Heart attack
  - ❑ Pacemaker
- ❑ Rheumatic Fever or Rheumatic Heart Disease
- ❑ Artificial Joint Replacement:
  - ❑ Hip
  - ❑ Knee
- ❑ Blood Thinners
  What kind? _____
- ❑ Hepatitis (A, B, C)
- ❑ Tuberculosis (T.B.)
- ❑ HIV Positive
- ❑ Thyroid Problems
- ❑ Liver Disease
- ❑ Diabetes
- ❑ Lung Disease
- ❑ Asthma
- ❑ Kidney Disease
- ❑ Chemotherapy
- ❑ Epilepsy or Seizures
- ❑ Fainting Spells
- ❑ Organ Transplants
- ❑ Bleeding Disorder

2. ARE YOU ALLERGIC TO:

- ❑ Aspirin
- ❑ Penicillin
- ❑ Local Anesthetic
- ❑ Codeine
- ❑ Latex
- ❑ Tylenol
- ❑ Epinephrine
- ❑ Other. Please List:
  _____
  _____

3. Please list all medications you are currently taking.

_____
_____
_____

4. If you are female, are you currently pregnant? ❑ Yes ❑ No
(Antibiotics may alter the effect of oral contraceptives.
If antibiotics are prescribed, you may need to consult your physician.)

5. Are you currently being treated by a physician? ❑ Yes ❑ No
If so, please explain. _____
_____

6. Have you had any surgery in the past two years? ❑ Yes ❑ No
If so, please explain. _____
_____

7. Do you premedicate before dental treatment? ❑ Yes ❑ No

8. If you premedicate, what do you premedicate for? _____

9. General Physicians Name _____
Phone _____

OFFICE PAYMENT POLICY

IF YOU HAVE DENTAL INSURANCE
Please help us with your claim by completing the following:

Insured person's name _____

Address _____

_____

Birth date _____ Soc. Sec. # _____

Relationship to patient (spouse, parent, etc.) _____

Employer's Address _____

_____

Employer's Phone _____

Name of Plan _____

Group Number _____

Contract Number _____

This is a referral practice, and a mutual respect to obligations is essential to permit our business to be conducted on an efficient and friendly basis. Therefore, to avoid misunderstandings concerning payment of accounts, please note that endodontic treatment is usually completed in one visit and must be paid in full. We will be happy to file insurance claims for you at no extra charge, if the insurance company will also issue a check payable to the dentist. In addition, you must provide our office staff proper information (Dental Insurance Card, Social Security # and Date of Birth of the person you are filing dental insurance under). The estimated difference that the insurance does not pay must be paid the day of the office visit.

Your insurance is a contract between you as a subscriber, and the insurance company as insurer, involving our office, Montgomery Endodontics, P.C. only indirectly. Therefore, any controversy which might arise over your Insurance company's handling of your claim is for you to resolve. Any discrepancy between the Insurance company's allowance and your total indebtedness remains your responsibility. Any insurance claim that has not been paid within 30 days of treatment will be billed back to you.

Montgomery
ENDODONTICS, PC
James J. Kamburis, DMD

American Association of Endodontists
Specialty Member

We are a PPO provider for the following insurance companies, Blue Cross Blue Shield of Alabama and Delta Dental, we also participate with Concordia National Fee for service, Concordia Advantage and Advantage Plus If you are covered under a plan for which we are not a provider, fees would be due in full at the time of service.

A finance charge of 1 ½% per month will be applied to all accounts over 30 days old.

( ) I have dental insurance

( ) I will pay in full

( ) I will pay by check or cash

( ) I will charge to MasterCard____ Visa ____ Discover ___

( ) I will charge to CareCredit

I hereby assign, transfer, and set over to Montgomery Endodontics, P.C. all rights, title and interest to my dental reimbursement benefits under my insurance policy, I authorize the release of any dental information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges for my dependents, or myself whether or not they are covered by insurance. I, the undersigned, hereby agree that, in the event of default in the payment of any amount due, and if this account is placed in the hands of a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including collection agency and attorney fees and court costs incurred.

_____

SIGNATURE OF RESPONSIBLE PARTY

_____

DATE

ENDODONTIC INFORMED CONSENT

Informed consent advises patients of the general nature of treatment, the medical acceptable alternatives, and the substantial risks inherent in the proposed procedures. In signing this consent form, you are agreeing that you have been advised of these matters to your satisfaction and understand that one alternative is not to have any treatment at all with a full understanding of the risks and hazards of declining treatment.

ENDODONTICS. Endodontics (root canal) therapy is performed in order to try to save a tooth which otherwise would need to be removed. The word "endodontics" comes from "endo" meaning inside, and "odont" meaning tooth. The actual procedure involves removing inflamed, infected, or damaged tissue from inside the tooth, and cleaning, filling, and sealing the remaining space. Conservative root canal therapy, or when needed, endodontic surgery, accomplishes this. Multiple treatment appointments are usually required.

OTHER TREATMENT CHOICES. These include: 1) no treatment, 2) waiting for more definite development of symptoms, or 3) tooth extraction. Risks involved in these choices may include pain, infection, swelling, loss of teeth, and infection to other areas.

ENDODONTIC EXAMINATION. Endodontic diagnostic testing in conjunction with radiographic interpretation attempts to isolate the inflamed, infected, or damaged tooth or teeth.

RISKS OF DENTISTRY. Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesic (pain killers), anesthetics, injections of anesthesia, irrigation media, and dental materials. These complications include: sensitivity, swelling, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent, spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY. Included (but not limited to) are additional/alternate tooth or teeth requiring endodontics, sterile instruments separating and remaining within the root canal, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns, or porcelain veneers, loss off tooth structure in gaining access to canals, over-extension or under-extension of root filling material, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery extraction. The complications may include: blocked canals due to fillings or prior treatment, natural calcifications, separated instruments, curved roots, periodontal disease (gum disease), tissue lesions, resorption, and fractures of the teeth.

X-RAYS. A series of X-rays is required for endodontic treatment.

MEDICATIONS. Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Antibiotics may inhibit the effectiveness of birth control pills.

CONSENT. I, the undersigned, being the patient (parent or guardian of above minor patient) consent to the procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved (such as a crown or filling) within several weeks.

I understand root canal treatment is an attempt to save a tooth, which may require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require treatment, surgery, or even extraction.

SIGNATURE OF RESPONSIBLE PARTY

DATE

Montgomery
ENDODONTICS, PC
James J. Kamburis, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____, have read a copy of this office's Notice of Privacy Practices.

_____

(Please Print Name)

_____

(Signature)

_____

(Date)